SENT VIA EMAIL OR FAX ON
Mar/22/2010

True Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Mar/19/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
ESI @ C3-C7 with fluoro

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management
Subspecialty Board Certified in Electrodiagnostic Medicine
Residency Training PMR and ORTHOPAEDIC SURGERY

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
OD Guidelines
Denial Letters 2/1/10 and 3/3/10
4/27/09 thru 5/29/09
Dr. 5/6/09 thru 3/4/10
Dr. 7/17/09 thru 3/5/10
Dr.

PATIENT CLINICAL HISTORY SUMMARY
This is a man injured on xx/xx/xx. He developed right shoulder and neck pain He was treated for the right shoulder pain and improved with local steroid injections and an ESI. He was felt

to have rotator impingement. He complained of neck pain. The neurologicla exams were reported as normal. An MRI done on 5/27/09 described central protrusions at C5/6 and C6/7 with bilateral neural impingement at C6/7. He began having tingling in the right thumb, index and mid finger. This was first attributed to CTS, but an EMG on 9/29 found evidence of a right C7 radiculopathy. He was having paresthesias in the right C7 dermatome. Dr. performed an ESI at C5/6 on 8/5/09. The man reportedly had relief until the symptoms occurred a few weeks before the 9/11/09 visit. Dr. performed a second ESI, but I do not have the date. It was not done by Dr. 9/29/09 note and not commented upon in his 10/27/09 note. The second had been completed before. Dr. noted on 9/11/09 of his plans for 3 Cervical ESI at C5/6 and recommended 3 at C6/7 in his 3/5/10 note. The second C5/6 was done prior to the 12/9 /09 visit with Dr..

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

The ODG permits ESIs for pain relief associated with therapies. There is the required dermatomal distribution of the symptoms, which was present. There is required radiological and EMG abnormalities, which were present. There are required physical findings. Some examiners found weakness in the shoulder girdle muscles, but only Dr. found generalized weakness. The ODG permits two transforaminal levels to be injected at one time or one interlamina level. The IRO reviewer is not sure why only was injected or what technique was used. Repeat injections require at least 50% relief for at least 6-8 weeks. The amount of relief was not described. The first injection provided relief for less than 5 weeks especially since Dr. said the symptoms had been returning weeks before the follow up appointment in September, 37 days post injection. The IRO reviewer has no information of when the second injection was performed and how effective was it. Further, the ODG does not advise more than 2 ESIs, and does not support the series of 3 advised by Dr. Therefore, there was no information provided to justify a third ESI at C5/6. The plan for 3 C6/7ESIs would also not meet the ODG stipulations. Therefore, the requests are not medically justified by the information provided.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)